

# **Office of Adults with Cognitive and Physical Disability Services**

## **Shared Living Handbook**

**Effective October 1, 2010**

**Introduction:** Shared Living is one of a range of housing and support options for individuals with intellectual disabilities. This program is supported by the Department of Health and Human Services through the MaineCare program (Section 21, Home and Community Based Waiver Services).

In recent months the Shared Living Program has undergone some changes. On July 1, 2010, the Office of Adults with Cognitive and Physical Disabilities Services (OACPDS) assumed the responsibility for Direct Support Professional training and the Medication Administration training required for all shared living providers. On October 1, 2010 OACPDS assumed responsibility for developing the Person-Centered Plan and has an enhanced role in quality assurance, particularly in the quality of life experienced by the individual living in a shared living home. These functions are the role of the case manager. Case managers work either for state government (OACPDS) or for an agency specifically designated by OACPDS to provide case management services.

Administering Agencies provide essential support services to Shared Living Providers; such as recruitment, approval to be a provider and quality assurance, just to name a few. One area that is important to note (and this has been the case all along): the Shared Living Provider is self-employed and provides shared living as a contractor of an Administering Agency.

There is more about the roles of the shared living provider, administering agency and case manager in this handbook. OACPDS is strongly supportive of this program and will take steps to continue to grow this option for housing and living supports for individuals with intellectual disabilities. This Handbook is designed to

provide a guide to the Shared Living Program, including expectations and outcomes.

**What is Shared Living?** Quite simply, shared living provides a home and supports for an adult with intellectual disabilities in the home of an approved contract provider. Shared living is somewhat like foster care, but different in emphasis in that the home is a more cooperative sharing of space and supports between adults. The individual becomes part of the fabric of the shared living provider's life: the provider's family, home and community.

**Who is shared living for?** Shared living is for any individual with intellectual disabilities that prefers to live in a family-type home, who is eligible for MaineCare services under Section 21 Home and Community-Based Waiver and for whom the Person-Centered Planning team has determined this to be an appropriate living option. Shared living can be for any individual, if the correct match is found. For example, the program is generally not designed for individuals with nursing care needs, unless the provider has the experience and skills to meet those needs.

**Benefits of the Shared Living Model:** Shared living provides many benefits to both the individual and the shared living provider. Some of the benefits include:

- Inclusion in the community has been and continues to be a major focus of supports for people with disabilities. The Shared Living model has proven to be a good means for providing true inclusion in a person's community, if the individual is matched and well supported by the Shared Living Provider.
- Shared Living can provide both a stable support system and a higher quality of life for the person receiving services. The issue of staff people "revolving" in and out of the person's life is minimized.
- Shared Living can also provide a stable, flexible, higher quality of life for the Shared Living Provider.

- This model provides the training and service quality review needed to assure the system (and the person served) of the highest possible quality and cost-effectiveness of the services.

### **What are the Expected Outcomes?**

The expected outcomes of shared living are that the individual has an improved quality of life through:

- Becoming part of the provider's family. The individual is welcomed into and becomes a member of the family, participating in family activities.
- Receiving services as identified in the plan and making progress towards goals.
- Becoming part of a community. Community activities are a routine part of the individual's life.
- Continuing to engage in personal interests and relationships, including relationships with his/her family and friends.

### **Who can be a Shared Living Provider?**

A person who has a desire to share his/her home and family life with an individual with intellectual disabilities may become a shared living provider, if he/she has:

- Successfully passed background checks, along with all other family members who live full- or part-time in the home or who will provide support to the individual,
- Successfully passed interviews and home visits to assure that the provider is both qualified to provide services and has a home that meets all health and safety environmental standards,
- Successfully met training requirements, and
- Verified that he/she has time to provide daily services/supports that meet the needs of the individual and work towards the goals identified in the Person-Centered Plan.

Once all these requirements are met, the provider must be certified by an Administering Agency, have a contract with that agency and continue to meet all requirements.

### **What is the role of the Shared Living Provider?**

A shared living provider has many responsibilities and plays a pivotal role in the life of the individual sharing his/her home as well as the individual's family. The following is a summary of that role. The Shared Living Provider:

- Provides care on a 24-hour-a-day basis.
- Maintains a clean, healthy living environment, in accordance with the Environmental and Safety Standards and any necessary consumer-specific environmental or safety standards.
- Assists in transition/move-in plans and move-out plans.
- Participates as part of the Person-Centered Planning Team.
- Attends to the individual's physical health and emotional well-being.
- Includes the individual in family and community life, assisting that person to develop healthy friendships and community activities.
- Provides community access to services and activities desired by the consumer, including religious affiliation (if desired), physical activities, shopping, volunteering, etc.
- Attends all training as required by OACPDS, the Person-Centered Planning team and/or the Administering Agency.
- Maintains professional daily documentation of the services provided to the individual. This includes progress toward the goals and activities identified in the Person-Centered Plan.
- Maintains daily documentation of all medication administered to the individual, in accordance with medication administration standards.
- Provides nutritious meals and snacks.
- Provides for transportation to appointments, activities and employment.

- Reports any unusual incidents to the case manager, administering agency and, when appropriate, through the Reportable Events Reporting System.
- Maintains homeowners or renter's insurance at all times.
- Maintains a properly registered, inspected, insured and maintained vehicle.
- Protects the confidentiality of all individual-related documents and information.
- Maintains open communication with the case manager, Administering Agency and Person-Centered Planning Team.
- Enters into a contract for professional support with the Administering Agency.
- Reports to the Administering Agency any changes in household members or legal status of household members.

### **What is the role of the Administering Agency?**

Administering agencies approve qualified applicants to be shared living providers, assist with matching individuals and providers, provide quality assurance reviews, and provide billing on behalf of and consultation to shared living providers.

### **Administering Agencies:**

- Perform **all recruitment activities**, including advertising, interviewing, conducting home visits and reference and background checks. The agency certifies that each provider and his/her home meet criteria to be a shared living provider.
- Are part of the **matching** process – Agencies participate with the case manager and individual on home visits to answer questions for the individual and families and to assist with decision-making on provider selection.
- Conduct **quality assurance** activities as follows:
  - Maintain regular contact with the Shared Living provider.

- Assure the provider completes daily documentation, as required by MaineCare. Documentation may be maintained at either the shared living provider home or at the Administering Agency offices, but must be available for auditing purposes.
- Conduct home visits as specified in the Person-Centered Plan to assure compliance with Health and Safety Codes, appropriate documentation (progress notes and medication administration reports) and general requirements for an appropriate home environment. At a **minimum**, the Administering Agency must do a home visit every other month, with phone contact during the month that the home is not visited. The agency must share a copy of the home visit tool report with the case manager.
- Conduct Criminal and DMV background checks initially and every two years thereafter. Conduct any other background checks required; such as those pertaining to Child Protective and Adult Protective actions, etc.
- Receive reports on medication errors and reportable events.
- Report to OACPDS any issues with medication administration, documentation or any other significant issues impacting ongoing certification.
- Make recommendations to the Shared Living Provider regarding appropriate record keeping and consumer care.
- Provide MaineCare **billing** services for the Shared Living Provider.
- Provide **Professional support** – provide general consultation to provider, facilitate access to any needed additional training and assist with emergency backup when needed.
- **Document all quality assurance** activities, including home visits, phone consultations and recommendations.
- **Partner with the case manager** to share information and coordinate activities such as home visits. Share any consumer- or home-related

concerns with case manager. Partner with other Person-Centered Planning Team members.

- **Report concerns** to the case manager and, when necessary, to the regional office of OACPDS.

## **What is the Role of the Case Manager?**

Case managers perform important functions in the following areas: Referral, Matching, Transition, Post Placement follow-up, Ongoing Checks and Quality Assurance, as well as assuring the development of the Person-Centered Plan.

- **Referral:** The Case Manager is responsible for assuring that shared living is identified as a needed service in an individual's Person-Centered Plan or service plan. After meeting with the individual's team, a de-identified thumbnail sketch is developed, describing in a paragraph the needs identified relative to the individual wishing to live in a shared living home, and any unique wishes or requests (such as geographic location, interests, etc.). This request for proposal is sent to all administering agencies for review for possible matches.
- **Match Process:** The Case Manager is the primary team member that coordinates with administering agencies to find a shared living provider that is a match with the individual's specifications for a home. Administering agencies consult with the case manager on possible matches and this information is shared with the person seeking a shared living match. The case manager informs the individual and/or guardian about the possible matches identified.

Once a potential match has been identified, the team, under the coordination of the case manager, arranges for a visit to occur, during which the administering agency, shared living provider, and person to be served further explore the potential for a permanent match. This process is adjusted to reflect the needs of the individual, and therefore varies from

person to person as far as number of visits, overnight stays, or other considerations prior to a permanent transition.

- **Transition:** Once a match between an individual and a shared living provider is identified, the administering agency, case manager, and consumer/guardian arrange a transition plan to the home. The transition plan is developed in a pre-placement meeting prior to a permanent move. The case manager facilitates this meeting and authors the Person -Centered Plan, making any necessary changes, modifications, or adding any miscellaneous items needed to successfully transition the individual into the new living arrangement.
- **Post Placement:** The Case Manager assures the transition plan is implemented in collaboration with the administering agency, shared living provider, and the individual/guardian. The case manager conducts two home visits when the individual is present in the home with the shared living provider within the first two weeks of placement. On one of these visits the case manager uses the home visit review tool for shared living and documents findings within the home. Any pertinent information from the home visit tool is made available to team members for discussion.

More visits addressing any transition issues may occur at the discretion of the case manager.

A post-placement meeting occurs within 30 days after an individual has moved into a shared living home. The case manager facilitates the meeting and reports out the results of the two visits. The entire team assesses the transition plan and makes necessary recommendations.

At the post-placement meeting the case manager and team determine the future frequency of case manager and administering agency visits to the shared living home. At a **minimum**, the case manager must do a home visit every other month (some of which are unannounced) with phone contact

during the month that the home is not visited. The case manager must share a copy of the home visit tool with the Administering Agency.

- **On-going Checks and Quality Assurance:** As outlined in Section 13 of the MaineCare Manual regarding Case Management Services, it is the responsibility of the case manager to assure that the person's plan, including health and safety issues, goals and objectives, and coordination of services, is implemented by the team. The case manager is focused on the outcomes for the individual and works with the team to assure the plan is implemented.
- **Person-Centered Planning:** Case managers are responsible for authoring and monitoring the Person-Centered Plan in shared living homes. The case manager will assure that all services are included in the Person-Centered Plan, including shared living, community supports or work supports.

### **How do I apply to be a Shared Living Provider?**

If you are interested in becoming a shared living contract provider, please fill out the standard application form ([insert hyperlink here](#)) and submit it to the Administering Agency in your area ([click here for list](#)). Or visit <http://www.maine.gov/dhhs/OACPDS/DS/Services/index.shtml>